RUNNING HEAD: NCSS Crisis Bed Program

VERMONT AGENCY OF HUMAN SERVICES
DEPARTMENT OF HEALTH

CERTIFICATE OF APPROVAL APPLICATION/ PROPOSAL FOR VSH FUTURES CRISIS STABILIZATION/ INPATIENT DIVERSION BEDS

COVER PAGE

Applicant: **Northwestern Counseling & Support Services**

Project Title: **NCSS Crisis Bed Program**

Principal Contact: **Dr. Steve Broer / Director, Behavioral Health Services**

Address: **107 Fisher Pond Road** (street) **St. Albans** (town/city)

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PROJECT TYPE & AMOUNT

□ Capital expenditure exceeding $1,500,000 for construction, development, purchase or Long-term lease of property or existing structure
□ Purchase of a technology, technology upgrade, other equipment or a renovation with a cost exceeding $1,000,000
□ The offering of a health care service having a projected annual operating expense that exceeds $500,000 for either of the next two budgeted fiscal years if the service was not offered by the health care facility within the previous three fiscal years.

A. Proposed Capital Expenditure (Total Table 1) $ 0

B. Proposed Lease Amount (payment times term) $ 15,600 * I certify to the best of my knowledge and belief, that the information in this application is true and correct and that this application has been duly authorized by the governing body of the applicant. * $1300 x 12 months

CERTIFYING OFFICIAL: Denise Payea, Controller

(Name & Title)

SIGNATURE: Denise M. Payea

DATE: 2/9/07

ABSTRACT

NCSS Crisis Bed Program

The Behavioral Health Division at Northwestern Counseling & Support Services (NCSS) is responding to a Request for Proposals from the Department of Health's Division of Mental Health seeking financial support to develop their capacity to reduce the number of psychiatric hospitalization by offering a continuum of crisis support options. This proposal directly addresses a long-standing need identified in the division's System of Care Local Priorities to "Increase community acute care and hospital diversion resources".

This proposal will describe the NCSS Crisis Bed Program and illustrate a partnership with the Behavioral Health Division's Standing Committee, peer support group, Northwestern Medical Center, and local providers. The components of this proposal will include a range of flexible service options to meet a range of needs. A continuum of crisis response options to be described include: a) CRT Crisis Outreach- intended for consumers with severe and persistent mental illness to prevent emergency room and hospital screening utilization, b) Community Hospital Observation Bed- intended for consumers presenting with acute psychiatric symptoms needing stabilization services, 3) 2 Crisis Beds- intended for crisis stabilization and step down from psychiatric hospitalization.

The proposal will describe how this project will function as part of the larger system of care, the role of Behavioral Health Division's Standing Committee in program and policy development, who will be served, operations related to: admission and discharge practices, staffing, program supervision and medical oversight, peer support and peer services, treatment modalities, and program evaluation. This proposal will also describe potential areas for program expansion as additional funding becomes available.

Application/Proposal Narrative

Program Goals

The primary goals of the Crisis Bed Program are to provide safety and stabilization of symptoms to prevent the need for psychiatric hospitalization, to be a resource in transitioning consumers from hospitals by reducing their length of hospital stays, and to support successful transitions back into the community to prevent re-hospitalizations. The model for this proposed community-based treatment program includes: CRT Crisis Outreach, Community Hospital Observation Bed, and two Crisis Beds. A flexible staffing pattern with peer services and peer support and additional support from existing programs are intended to achieve the goal of hospital diversion for the majority of consumers served. Crisis Beds services are also intended to prevent re-hospitalization by supporting transition plans of consumers from hospitals to step-down use of the crisis bed or other services. The proposed Crisis Bed Program will be integrated into existing NCSS crisis services, Community Rehabilitation and Treatment (CRT), and outpatient programs. This program also builds on collaborative goals between the local care providers, Behavioral Health Division's Local Standing Committee, and principles described in the VSH Futures Report from the Crisis Bed Workgroup (2006).

1. Required Program Elements for Crisis Stabilization / Inpatient Diversion Bed Capacity. Proposals entertained under this RFP must be responsive to the following criteria and program goals. Please describe *how* the following program guidelines and characteristics would be met in the proposed program. Describe the project with sufficient detail for readers to understand the magnitude, complexity, and major elements of what is being proposed.

1.1 The service or programs proposed by the applicant for this RFP will be completely voluntary. How will prospective clients be encouraged to use the program?

This completely voluntary program will encourage consumers and providers to use the program through a community awareness plan, which will include support from NCSS Community Relations Department and include press releases, local TV program describing new services, radio public service announcements, and other media. It is anticipated that the existing crisis staff at NCSS will be able to direct the majority of referrals since they have primary contact with local emergency personnel, the regional homeless shelter, and others community entities across the two county area. Awareness will also be enhanced by the use of the existing electronic crisis alter system developed to increase communication to the crisis team on individual at particular risk of crisis. Use of the CRT Crisis Plans will be instrumental in the CRT Crisis Outreach option. Collaboration with Northwestern Medical Center's Emergency Department in providing an in-service for their staff on use and referral of the Observation Bed option will occur. The Crisis Team will have a current information on availability of the 2 Crisis Beds and will have the capacity to initiate referrals. The existing crisis staff for NCSS will manage the flow of these options on a 24 hour/7 day week basis and will know availability of resources to respond with any of the proposed crisis options.

1.2 How will the new crisis bed capacities proposed function as part of the larger care management system and system of care?

The proposed Crisis Bed Program will function as part of the larger care management system and system of care by:

a) Becoming part of the network of Crisis Bed Program providers and supporting recommendations from the Care Management Workgroup (2006) and principles that guide the movement of clients through the system of care.
b) Developing the capacity to take referrals from across the State of Vermont.
c) Commitment to implementing common assessment measures. For example, the Level of Care Utilization System (LOCUS) assists in developing a common understanding of acuity and level of care needs for consumers and how the current system of care can meet those needs.
d) Commitment to implement common skills development and treatment programs. For example, UCLA Skills Modules (UCLA) and Dartmouth's Illness Management & Recovery (DIMR) curriculums have been implemented in various programs across the state and have the potential to increases continuity of treatment for consumers' across all settings.
e) Commitment to developing peer support and peer services with other Crisis Bed Programs in the system of care.
f) Commitment to a co-occurring orientation with a welcoming perspective and appreciation for the stages of change in the recovery process
g) To be an active participant in improving the quality of the system of care in Vermont.

1.3 Who will be served in the program? How will the applicant assure that the program is available to respond to the general needs of the adult acute mental health care system and is available to individuals 18 years or older, not limited to CRT consumers?

The Crisis Bed Program will serve adults 18 years and older who present in crisis and are at risk of a more restrictive psychiatric hospitalization. It is common for the NCSS crisis team to encounter an adult experiencing an acute crisis who gets hospitalized. The typical profile of someone like this is that he or she is not experiences a severe and persistent mental illness, is not engaged in NCSS services, and does not follow-up with NCSS services substantively following discharge from the hospital. The proposed Crisis Bed Program will create a necessary diversion alternative and perhaps, because services are delivered through NCSS, increase the possibility for meaningful engagement in other NCSS services to prevent re-hospitalization. The CRT Crisis Outreach option is intended as a proactive intervention for preventing utilization of the local hospital's Emergency Department. It is anticipated that consumers from CRT programs will be utilizers of the observation bed and Crisis Bed options as well. Adults not in the CRT program will be utilizers of the Observation Bed and Crisis Bed options.

1.4 How will the program provide:

a) Daily medical oversight

The Behavioral Health Division currently employs three psychiatrists, one nurse manager and one staff nurse. Our Medical Director, Dr. Steve Sobel, has expertise with adults, with a particular interest in geriatric care. He provides liaison consultation to several nursing homes in our area. Dr. David Mooney has experience with children and adults and provides Liaison consultation to Northwestern Medical Center daily and is anticipated to play a role in supporting the hospital's Observation Bed option. Dr. Luna has experience with children and adults and, along with Dr. Sobel and Dr. Mooney, will provide on-call services through the Behavioral Health Divisions existing crisis team. Each psychiatrist also schedules an emergency slot appointment, which is managed through the crisis service. Our nursing service provides support to our psychiatry service and also makes regular on site contact with our residential programs. It is anticipated that nursing will play a very active role in each service option in the Crisis Bed Program. Consistent with the operation of our CRT residential programs, our Nurse Manager and Medical Director will take a lead in developing and implementing medical policies and protocols.

b) Daily access to a psychiatrist

Daily access to psychiatry will occur through daily crisis morning reports briefings, daily psychiatry emergency slot availability, liaison support at Northwestern Medical Center, and direct support at the Crisis Bed Program. As Medical Director, Dr. Sobel will be reviewing and authorizing medical policies and protocols. It is anticipated that Dr. Mooney will take and active role with the Medical Center's Observation Bed Option.

c) Peer services and support

Peer services and peer support are an important component to the success of this proposed program. Peer supports have been found to have a positive impact on consumers response to treatment, the course of treatment, and in preventing re-hospitalization of individual experiencing co-occurring disorders (Drake, McHugo, Clark, Teague, Ackerson, Xie, & Miles, 1998). While the design and implementation of this service needs to be discussed further with the division's program standing committee and Northwest Peer Support Group, it is anticipated that peer services and peer support will initially involve enhancing our existing peer staff to support the delivery of skill based recovery curriculums (UCLA Skills Modules & DIMR curriculum). Peers and crisis staff will participate in curriculum trainings and develop modalities for delivering such skills based trainings. During the program's pre-implementation phase, it is possible to envision an individual training format which will move to a group training format where consumers who participate in any aspect of the crisis program are invited to participate in skills based training. It is possible to envision a broader invitation of skills groups to other consumers who may not directly be involved in the Crisis Bed Program, yet who may benefit from such training and support. Individual peer support for consumers in the Crisis Bed Program will be instrumental in facilitation of additional social support. Peer support can play a critical role in linking consumers with the peer group and other healthy supports in the community. Peer support can play a role in staying in contact with consumers who have participated in the program after their discharge. Our current peer staff will have the capacity to follow-up with consumers after

discharge to determine if the discharge plan had been implemented successfully, complete consumer satisfaction and other program evaluation measures, and make providers aware of needed modifications to discharge plans. It is anticipated that the statewide workgroup on peer support services, of which our CRT Clinical Coordinator and peer staff member are invited participants, will provide additional direction for the development of peer services and peer support.

d) Adequate staffing

While there are certain fixed costs with maintaining the two crisis beds, the innovativeness of the proposed Crisis Bed Program is to develop a staffing pattern with capacity to respond to a range of crisis situations described in the three service options (CRT Crisis Outreach, Observation Bed, Crisis Beds). The staffing model is intended to utilize staff consistently and efficiently in a variety of settings with the most critical needs. Two full time employees will be needed to staff the core components of this proposed program. In addition, an on-call system is needed to cover hours core staff are not available (see Appendix A- Proposed Budget). The existing crisis team, psychiatry and nursing services will supplement the program by providing additional support and oversight of program operations. (see Appendix B, Implementation Plan)

1.5 What specific treatment and support modalities will be offered and how do these relate to the clinical mission of crisis stabilization and inpatient diversion?

As stated earlier, the primary goals of the Crisis Bed Program are to provide safety and stabilization of symptoms to prevent the need for psychiatric hospitalization, to be a resource in transitioning consumers from hospitals by reducing their length of hospital stays, and to support successful transitions back into the community to prevent re-hospitalizations. To achieve these goals, services will be organized into three overlapping treatment and support phases: Assessment, Intervention, and Discharge Planning.

Assessment Phase

The Crisis Bed Program is designed to consider the broad range of crisis situations it will need to be responsive to. Some crisis situations are influenced by stressful life events, developmental transitions, onset of a major illness, relapse of a severe and persistent mental illness, adverse reactions to medications, and traumatic stress. To gain an understanding of these influences it is important to conduct an effective crisis assessment. The first point of contact will be through initial contact with crisis services and initial screening of presenting concerns. The screening will involve concerns expressed by the consumer and social supports. Consultation with the referral source and determining which Crisis Bed Program service option is most appropriate for a presenting need takes place during the screening process. Once a consumer is engaged in one of the service options (CRT Crisis Outreach, Observation Bed, Crisis Beds), a more structured assessment interview process will be implemented. It is anticipated that each consumer in the Crisis Bed Program will participate in a standard assessment and based on individual needs, other assessments will be provided. In addition to structured interviews, this program will utilize evidenced-based measures to assist with assessment, treatment planning, care management, and program evaluation. Below is a description of some assessment tools under consideration for implementation. If funded, a process for review of the assessment options to determine more specific assessment protocols will be conducted (see Implementation Plan, Appendix B).

- Level of Care Utilization System (LOCUS)- is a functional assessment tool which provides a clinical acuity rating and assists in determining the level of care a consumer may need. This type of care management assessment is essential for both treatment planning and when considering transitions to other treatment settings within the system of care as part of a care. The shorter LOCUS Risk Scale is also advisable in determining a daily risk score for consumers in the Crisis Bed Program.
- Crisis State Assessment Scale (CSAS)- measures a crisis state in terms of consumer's specific perceptions of trauma and effective problem solving.
- Beck Hopelessness Scale (BHS)- Evidenced based measure of hopelessness & relates to suicide risk [use with suicide episode group- see evaluation plan 4.2 (c)]
- Scale for Suicide Ideation – Worst (SSI-W)- rating scale that measure the magnitude of a consumer's beliefs, behaviors and attitudes and plans to commit suicide during a specific time period. [use with suicide episode group- see evaluation plan 4.2 (c)]

Intervention Phase

Assessment and intervention overlap from initial contact. For instance, interventions to ensure supervision and safety of consumer starts from the initial point of contact. As the assessment process reveals a better understanding of a consumer's needs, current interventions are modified (supervision & safety plan) and new interventions are developed to meet individual needs. The measures described above support both assessment and intervention objectives. In addition to determining consumer functioning across a variety of domains, the LOCUS and other care management tools assist with establishing a common language with other providers in terms of describing a particular level of consumer need in a program at a point in time and in making informed determinations of transitions within the system of care across programs. The CSAS will assist in determining which skills development modules will be most effective at the time of service. Similar to the use of the LOCUS, the proposed program intends to use similar skills development programs utilized in other parts of the state (UCLA, DIMR) to promote a common approach for consumers who move through the system of care. This is particularly relevant for consumers who are referred into the Crisis Bed Program from outside of Franklin and Grand Isle counties.

UCLA Social Skills and Independent Living Skills Modules- is a curriculum with eight modules focusing on: medication management, symptom management, community re-entry, recreation for leisure, basic conversation skills, substance abuse management, friendship and intimacy, and workplace fundamentals skills (Liberman, Wallace, Blackwell, Eckman, Voccaro, & Kuenel, 1993).

Dartmouth Illness Management & Recovery (DIMR)- is a curriculum that can complement other recovery curriculums (e.g. Wellness Action Recovery Plans) and focuses on: psychoeducation, behavior tailoring of medication, relapse prevention training, coping skills training, and social skills training (Pratt & Mueser, 2002).

Skills development will be delivered either through individual or group formats. Utilization of peer services to co-facilitate skills development groups is one of the objectives of this service.

Treatment Team facilitation to assess effectiveness of current treatment plans is another service within the intervention phase. Program staff will be skilled in facilitating a treatment team, involving consumers, family and other supports, and providers. Often, a crisis state activates consumers and providers to re-examine their perspectives and consider change. Treatment team meetings are intended to take a look at consumers' current treatment plans and identify areas where modifications are needed to support consumers' recovery goals.

Based on individual needs, other interventions within the Crisis Bed Program include: psychiatric consultation, nursing support, individual therapy, DBT and Healthy Living skills, and peer support services.

Discharge Planning Phase

Discharge planning also overlaps with the assessment and intervention phases and it is often helpful at the initial point of contact to ask: "what do you want your situation to look like after you get through this difficult time?" Supporting consumers with more effective community-based treatment plans and social supports can be a major contributor to a better quality of life and prevention of hospital admissions. The role of peer supports in linking consumers with the existing peer support group in the area and other peer resources will be essential. The discharge process is also important for supporting consumers to engage in other community-based treatments available through CRT and outpatient programs. For example, the CRT program offers several groups (family psychoeducation/Dartmouth model, co-occurring groups, wellness groups). The Dialectical and Behavior Therapy (DBT) program at NCSS is operated out of the outpatient program, which allows for a wider range of referrals. The DBT option may be particular effective for individuals who are not experiencing a severe and persistent illness, yet need continuing support in managing difficult emotions that place them at continuing risk for hospitalization. The discharge planning phase is also the time for consumers to complete post assessment measures to determine what type of changes they see in concerns that influenced the referral. This information will also be used as part of the program's evaluation. Follow-up satisfaction measures will be implemented and the role of peer support following discharge will be encouraged.

1.6 How will the proposed crisis bed program provide as much capacity as possible within appropriated resources?

By developing a range of crisis support options, it is anticipated that this proposed program will be successful in meeting a range of consumer needs that are not present in our current system of care. We also anticipate that the services provided through the Crisis Bed Program will benefit both our homeless shelter and local medical center's capacity in responding to increasing service demands.

1.7 Please provide the proposed admission, discharge and continued stay criteria for the program. Describe how referrals and discharges will be decided consistent with the inpatient diversion and step-down outcomes of the program.

Admission & Discharge- Upon notification of program funding, the program will formalize admission and discharge policies and protocols. It is anticipated that activation of CRT Outreach Services will be influenced by a contact from our crisis service, indicating a need to implement a previously developed CRT Individual Crisis Plan. The CRT Outreach service will be monitored through predetermined call-ins between the CRT Outreach worker and the Crisis Service staff on-call. Discontinuation of the service will be influenced by a decrease in risk and discussions with the consumer and the provider. Admission into Northwestern Medical Center's Observation Bed will be facilitated by the attending physician who will contact on-call crisis services. The crisis clinician on-call will do an initial assessment, consult with our psychiatrist on call and activate staffing option for the observation bed by notifying crisis bed staff on call. Since this is an acute option, medical and psychiatric stability criteria will drive discharge. It is possible that in some instance, consumers may be discharged to the community crisis beds. Admission into the Crisis Beds will be based on an initial screening interview and assessment by the on-call crisis worker, consultation with crisis bed staff, and whether the presenting clinical situation is manageable with clinical capacity at that time. On-call crisis staff will also be the point of contact from other providers seeking placement in the crisis beds from outside Franklin and Grand Isle counties. Discharge from the Crisis Bed Program will be based on substantive change in symptoms triggering referral and a reasonable discharge plan. On call psychiatry will be available for consultation with each admission and discharge in all of the Crisis Bed Program service options.

Continuing Stay Reviews- The CRT Outreach option is considered a short-term (approximately 4 to 6 hours) in-home or community support service. Individual referrals will be reviewed at the crisis morning report meeting, which is an existing structure for communication of crisis services across programs. It is also anticipated that any consumer who receives this service will be reviewed at the weekly CRT Clinical Coordinator's meeting and weekly all staff CRT clinical meeting. The previous review mechanisms will also be utilized with the Observation Bed option. For consumers engaged in existing NCSS programs, continuing Stay Reviews will be conducted by the primary staff (e.g., CRT Case Manager for CRT Consumer). Currently, CRT case managers conduct continuing stay reviews for consumers hospitalized in one of the designated hospitals. The framework described in the Acute Care Management program manual for CRT and crisis programs will continue to be applied. There may be instances when a CRT case manager is conducting a continuing stay review on a consumer in a designated hospital and can utilize the process to facilitate a shorter length of stay in the hospital to a "step-down" transfer to one of the NCSS crisis beds.

1.8 How will the program be cost effective, including?

- leveraging resources with existing programs in the network of Designated Agencies and Vermont's hospitals,
- coordinating with existing facilities and programs, and sharing medical resources

Model design is intended to provide a community-based respond to a range of situations, which typically result in more restrictive costly hospitalizations , by implementing crisis service options which are: flexible, timely, less expensive and restrictive than hospital care, supplemented by a range of other resources within

NCSS (crisis team, psychiatry, nursing, CRT program, outpatient services, expertise of leadership from Behavioral Health Division). Behavioral Health Division leadership team participates on several statewide coordination groups (Crisis Coordination, CRT Directors, Medical Directors, DBT Coordination). It is expected that staff from the Crisis Bed Program will be in contact with other designated agencies and hospitals throughout Vermont in either coordinating referrals into the program or working to coordinate earlier transitions of consumers from hospitals to step- down options within the Crisis Bed Program.

1.9 How will the program secure ongoing input from local program standing committees for program development and policy?

The Local Standing Committee for the Behavioral Health Division meets the second Wednesday of ever month. The committee is composed of consumers, family members and NCSS board members. This standing committee has invested considerable energy in expanding its membership and now has members who also are represented on other boards (State Standing Committee, Vermont Psychiatric Survivors, National Alliance on Mental Illness). This group has been active in other projects outside of monthly meetings. For instance, a workgroup was formed to develop the peer support group model. Another workgroup was formed to develop an action plan to address stigma. Each of the Standing Committee meetings is facilitated by a consumer who is also an NCSS board member. The Standing Committee meeting agenda typically include: a board update, division update, peer support update, stigma update, and a specific topic of discussion. Future topics include the transition to peer directed summer camping trip and Night of the Arts Event.

As part of the implementation plan for this proposed program (see Implementation Plan, Appendix B), the Local Standing Committee will be active in all phases of the proposed program (e.g., pre-implementation, implementation and evaluation phases). It is anticipated that there will be overlap in peers participating on the Standing Committee and providing peer support to consumers in the Crisis Bed Program. A structured format for discussing the program development will be developed and may include some of the following prompts: a) what is going well? b) are we on management timeline? c) what policies & protocols are being considered? d) what is the status of peer training on skills development and other areas identified?

1.10 Additional Considerations

In addition to consistency with the program characteristics and principles described above, review criteria for the RFP will also include the following considerations:

a) Proposals that promote geographic access to the following high priority locations in the corridors between White River Junction and north, and between Burlington and Bennington.

NCSS is located in the Northwestern part of the state and has no crisis bed program

b) Proposals that are prepared to develop a program on an immediate time frame.

The Implementation Plan for the proposed program (see Appendix B) illustrates how the proposed program is

prepared to move towards implementation. Specifically, the management plan for the Crisis Bed Program describes the process applied in the development of the proposal, pre-implementation activities following notification of funding, implementation phases, and program evaluation activities. The management plan list major tasks with due dates, persons responsible and status summaries. This task tracking system has been demonstrated as an effective tool for efficient program development and implementation.

c) Proposals most successful in leveraging the capacity of existing resources (such as hospitals and other programs that operate (24/7) with these new funds.

The design of this proposed program is based on a solid collaboration with the existing NCSS crisis team, well developed relationship with the Northwestern Medical Center, and other programs that operate on a 24/7 basis.

d) Proposals from designated agencies that do not have crisis bed programs currently.

Northwestern Counseling & Support Services service Franklin and Grand Isle counties and there is no crisis bed program in this region.

e) Proposals from designated agencies that may have a crisis bed program but that require a second location to assure access within reasonable distances.

Not applicable since no crisis bed programs exists in this region.

f) Proposals that offer both local and statewide access.

The proposed program will be accessible to consumers on local and state levels (see Section1.7)

2. Facility Details and Program Costs

Describe the facility and location for the planned service. Specify the capital and operating costs resulting from the project. Please keep this statement reasonably concise and provide the following applicable details:

2.1 For construction or renovation projects

Not applicable to the proposed program

2.2 For projects involving lease arrangements :

a) Indicate the duration, dates, and terms of the lease.

The proposed program will be leasing space for the amount of time the program is funded for. The lease will be renewed if funding continues.

b) Compare costs of lease with purchase option.

Given the funds in the budget for this proposal, purchasing a space is not an option

2.3 For projects involving the refinancing of existing debt
Not applicable to the proposed program

3. Local Governance Support and Relationship of Proposed Project to Agency Strategic Plan: COA Criterion 1

This proposed project has been presented to and unanimously supported by both the NCSS Board of Directors and the Behavioral Health Division's Standing Committee (see section 3.1). This proposal directly addresses a long-standing need identified in the Behavioral Health Division's System of Care Local Priorities to "Increase community acute care and hospital diversion resources." See section 1.9 for a detailed description of the Behavioral Health Division's Standing Committee and role in the proposed program.

3.1 Please provide information about how this proposal was reviewed and approved by the applicant's Board of Directors and the appropriate Local Standing Committee or Committees.

The January 8th Request for Proposal was announced at the Behavioral Health Standing Committee meeting on January 10th, discussions with individual standing committee participants continued from that date through the submission date. Standing committee participants also provided a letter of support from the standing committee for the proposed program. The Behavioral Health Director started conversations with Northwestern Medical Center's Director of Emergency Medicine about the observation bed option at their monthly coordination meeting on January 25th. The Behavioral Health Director also spoke with the Agency of Human Service Field Director about this proposed program on that date. The Executive Director for NCSS presented the proposed Crisis Bed Program to the agency's Board of Directors on February 7th. Copies of the proposal will be distributed to Standing Committee participants for the next Standing Committee meeting on February 14th. It is anticipated that representatives from the Standing Committee and peer support group will also be active participants in the presentation and review process following the submission of this proposal. (see Implementation Plan, Appendix B, for proposal development activities).

3.2 Please describe how this proposal is consistent with your agency's Strategic Plan or System of Care Plans. Please describe any public input or involvement that your agency has participated in or invited as part of the development of this proposal.

NCSS is currently conducting interviews for its current strategic plan. Surveys and interviews continuing to document the need for crisis beds and other alternatives to hospitalization from respondents across our two county region. This proposal directly addresses a long-standing need identified in the Behavioral Health Division's System of Care Local Priorities to "Increase community acute care and hospital diversion resources." See section 3.1 on involvement of Behavioral Health Standing Committee, NCSS Board and others in the development of this proposal. Appendix C of this proposal contains several letters of support for the proposed program:

1) Behavioral Health Division Standing Committee
2) Jim Tomlinson, Peer Support Group facilitator
3) Linda Ryan, Executive Director, Samaritan House
4) Dr. Ed Haak, Director, Department of Emergency Medicine, Northwestern Medical Center

3.3 If the proposal involves any new or reorganized services, describe how they will be coordinated with other services or providers in your area?

The clinical oversight and coordination will be integrated into existing structures and it is anticipated that additional structures will need to be developed. In terms of existing structures, each weekday morning there is a Crisis Morning Report Meeting, which is attended by treating psychiatrists, crisis staff, representatives from CRT, outpatient programs, and children's programs. Every Wednesday there is a large CRT Clinical Meeting where all available staff, supervisors, psychiatrists and the division director meet to review medication questions or concerns, recent hospitalizations & discharges, individuals with legal involvement, and general consumer updates. Every Wednesday the outpatient program meets with all therapists, a representative from crisis services, CRT, and children's programs. There is also a Division Leadership meeting two times each month and includes leadership across the division. The CRT program also has several other clinical and administrative oversight structures (small group supervisions, individual supervision, Clinical Coordinator's Meeting, Intensive Case Management, and Employment Services). It is anticipated that the staff from the newly formed Crisis Bed Program will be integrated into these structures and also receive individual and group supervision through separate meeting structures. Staff meetings with full time, on-call staff, and peer support providers will also take place. There is a monthly coordination meeting at Northwestern Medical Center and involves representatives from their Emergency Department, Champlain Drug and Alcohol Services, and NCSS. Participants from NCSS include our Medical Director, Behavioral Health Director, and Crisis Services Team Leader. The Director of Emergency Medicine facilitates these meetings and discussions on ways to improve coordination of emergency services is the primary focus. It is anticipated that there will be a need for a regular dialogue in the development of the Observation Bed option and that meetings beyond this meeting will be necessary during the pre-implementation phase of this proposed program.

4. Need for the Proposed Project: COA Criterion II

4.1 Please describe how this proposal is consistent with Vermont's Health Resource Allocation Plan (HRAP).

This proposed program directly addresses five of the six Vermont Health Resource Allocation Plan in its focus on the following H-RAP priorities:

1) Develop secure triage and assessment facilities in hospital emergency rooms
2) Add training and support for first responders to psychiatric emergencies
3) Increase resources for Designated Agency Emergency Services
4) Increase resources for psychiatric services at general hospitals
5) Increase resources for crisis/triage/diversion beds for mental health and substance abuse

The only H-RAP priority not addressed in this proposed project, "consider proposal identified in the 2005 ADAP public health report". NCSS is not the designated substance abuse provider in the two county area it services.

4.2 As this project is in response to a Request for Proposals, it is not necessary to demonstrate need for new crisis stabilization / diversion beds. Instead, please describe how the program will meet the primary outcomes of reducing and diverting psychiatric inpatient use. What specific targets, from the outcomes listed below, will the program meet?

a) Reduce inpatient psychiatric admissions to VSH and General Hospitals

The design of this proposed program is intended to reduce the psychiatric admission to VSH and designated hospital with inpatient psychiatric facilities through the continuum of crisis response options proposed (CRT Crisis Outreach, Observation Bed at local hospital, 2- Crisis Beds). Related to this model is the need to identify high utilizers of inpatient hospitals and develop a plan for utilization of proposed Crisis Bed Program resources.

b) Reduce the number of inpatient days at VSH and General Hospitals

It is anticipated that the number of inpatient days can be reduced by utilizing the proposed Crisis Bed Program resources as a "step-down" function. Staff, particularly in the CRT program will need training on how to consider Crisis Bed Program resources when they are conducting Continuing Stay Reviews.

c) Please describe the methodology and data employed to develop these outcome targets.

There are many factors to consider when developing a sound program evaluation of such a crisis bed program. Essential evaluation activities will represent and effort to: a) describe the population of adults who will utilize the Crisis Bed Program, b) summarize their pattern and level of functioning during their placements, c)

provide some preliminary follow-up data as a means of determining outcomes. There will be a specific emphasis on a subgroup of adults who meet the definition of suicide episode proposed by Pfeffer, Klerman, Hurt, Lesser, Peskin, and Siefker (1991): "A suicide episode is defined as the occurrence of either suicidal ideation, threats or attempts of suicide within a one year period" (p.610).

Data gathered on treated adults during the initial phases of this proposed crisis bed program will influence ongoing program development and a more comprehensive program evaluation design. Enhancing the capacity of the Crisis Bed Program to continually evaluate its treatment model can lead to a continuous quality improvement plan. In addition, this process will support the goal of adding the Crisis Bed Program for review and accreditation in the agency's next review by the Council on Accreditation of Rehabilitation Facilities.

In addition to targeting a decrease in inpatient psychiatric hospitalization, a central question is whether consumers served by this proposed Crisis Bed Program can be served more effectively than traditional inpatient psychiatric hospitals? Questions to be answered include:

1) What are the characteristics of adults served in the Crisis Bed Program?
2) How many of the adults served in the Crisis Bed Program went into more restrictive placements (e.g., psychiatric hospitals, residential treatment facilities, department of correction facilities)?
3) How many of the adults served in the Crisis Bed Program did not transition into more restrictive settings?
4) What can be said about the suicide episode group in terms of gender, depression, suicidal ideation, substance use, functioning, and suicidal behavior at follow-up?
5) What is the level of satisfaction and support for the Crisis Bed Program among consumers, peers, and providers?

Evaluation Framework

Consumer Demographics	Consumer Functioning	Follow-up & Satisfaction
• Gender • Age • Month of Stay • Length of Stay • Town • County • Referral Source • Legal Status • History of Hospitalizations	• Primary Diagnosis • Secondary Diagnosis • Substance Use • Global Assessment of Functioning • Risk Assessment Scale? • Locus Score? • Depression Screen score? • Suicide Ideation score?	• Living situation • Legal Status • Hospitalizations • Use of Crisis Service • Use of Local Hospital • Medications • Perceived improvement • Satisfaction Scores (consumer, referral source

4.3 Please describe how service utilization and program effectiveness will be reviewed?

NCSS utilizes a variety of clinical and administrative mechanisms to review service utilization and program effectiveness. The clinical oversight and coordination will be integrated into existing

structures and it is anticipated that additional structures will need to be developed. In terms of existing structures, each weekday morning there is a Crisis Morning Report Meeting, which is attended by treating psychiatrists, crisis staff, representatives from CRT, outpatient programs, and children's programs. Every Wednesday there is a large CRT Clinical Meeting where all available staff, supervisors, psychiatrists and the division director meet to review medication questions or concerns, recent hospitalizations & discharges, individuals with legal involvement, and general consumer updates. Every Wednesday the outpatient program meets with all therapists, a representative from crisis services, CRT, and children's programs. There is also a Division Leadership meeting two times each month and includes leadership across the division. The CRT program also has several other clinical and administrative oversight structures (small group supervisions, individual supervision, Clinical Coordinators Meeting, Intensive Case Management, and Employment Services). It is anticipated that the staff from the newly formed Crisis Be Program will be integrated into these structures and also receive individual and group supervision through separate meeting structures. Staff meetings with full time, on- call staff, and peer support providers will also take place. In terms of administrative structures, NCSS has developed an Administrative Intake Team, which consists of representatives from reception, medical records, billing, technology, accounting, and quality assurance. Clinical leadership and staff participate in these meetings when new initiatives are being planned. It is anticipated that the pre-implementation phase of this proposed program will involve several Administrative Intake meetings with monitoring meetings in subsequent months.

Future Development of NCSS Crisis Bed Program

As additional funding becomes available, it is anticipated that each of the service options described above can expand in scope and clinical capacity. Additional funding will allow for an expansion of the CRT Crisis Outreach service to a Mobile Crisis Outreach service for individuals beyond the CRT program. Additional funding will enable the Community Hospital Observation Bed, intended for consumers presenting with acute psychiatric symptoms needing stabilization services, to have capacity to serve consumers beyond an acute episode and for a longer period of time than currently proposed. Additional funding will provide an opportunity to increase capacity of the currently proposed 2 Crisis Beds to at least 4 Crisis Beds. Additional funding will increase staffing capacity of these options and also expand peer support services. Additional funding could also support a stronger case management and follow-up capability, which will increase the probability of more successful consumer outcomes. This type of model expansion will further enhance the NCSS Crisis Bed Program's goals to reduce both the psychiatric hospitalization rate and utilization of emergency department resources at local hospitals.

5. Organizational Structure, Affiliations and Operations: COA Criterion III

5.1 The entity making this application / proposal must be a Vermont Mental Health and/or Developmental Services Designated or Specialized Service Agency.

Northwestern Counseling & Support Services is a community behavioral health and developmental services agency in St. Albans, Vermont that provides a comprehensive range of professional services to children, adults and their families throughout Franklin and Grand Isle Counties. A professional staff provides comprehensive services and support, including

psychiatrists, psychologists, social workers, nurses, teachers and advocates. We offer targeted programs and services to fit each need through three main divisions; Behavioral Health Services; Children, Youth & Family Services and Developmental Services. In January 2007, Commissioner Moffatt informed the Behavioral Health Division that it was successful in meeting re-designation standards for CRT, Emergency Services, and Adult Mental Health Programs.

5.2 (if applicable) If the applicant is not a single designated agency but rather a consortium of agencies or if the designated agency applicant intends to sub contract for the service:

NCSS is the sole applicant for the proposed program

a) **Please provide details about the organization's governance, organizational structure**

NCSS meets standards as a Designated Agency, which includes the requirement of having certain organization governance and structures. NCSS has an executive director who reports to the NCSS board of Directors, composed of a cross section of approximately 22 community members. Several board members are also consumers of services and have overlapping membership, along with other board members on program standing committees. The January 2007 Designation Report from the Department of Health, Division of Mental Health indicates that NCSS is in compliance with Regulation 4.2 (governance) which refers to Board of Directors as representative of demographics in area service, Bylaws, Board of Director's Responsibilities, Program Standing Committee composition, policy and responsibilities. With regards to agency organization (Regulation 4.3) the designation report indicates NCSS meets standard in all areas: consistent agency vision and mission, communication and collaboration between managers, staff and administration, timely and shared organizational decision making, positive staff morale, satisfaction and feedback, communication and collaboration with stakeholders, positive community presence, current organizational chart.

b) **Plans for consumer involvement in governing the entity**

The NCSS board is composed of several consumers who have overlapping membership, along with other board members, on program standing committees. The Behavioral Health Division's Standing Committee is composed mostly of consumers and family members and will be active participants in the development of the proposed Crisis Bed Program (see Section 3)

c) **Please describe any key organizational arrangements necessary to implement this proposal such as contracts, affiliations, or partnerships and the financial or other contributions that any affiliated organization or related party will be making to the project.**

The Crisis Services at NCSS are affiliated with Northwestern Medical Center as their first responder for behavioral healthcare needs. All Crisis workers and psychiatrists participate in the application and credentialing process to be granted privileges to provide services on hospital grounds. One of our psychiatrists, Dr. David Mooney, provides consultation/liaison services through a contractual agreement between the medical center and NCSS. This involves two hours/day of psychiatric consultation on site of the hospital to assist medical providers and patients with particular consultation needs.

6. Financial Feasibility and Impact Analysis: COA Criterion IV

6.1 Please describe how the project will provide maximum service capacity within available resources.

The design of this proposed program is intended to allow for flexibility in meeting anticipated crisis needs whereby staff are part of a broader Crisis Response Team capable of providing a range of responses to a range of crisis situations that place consumers at particular risk of hospitalization. The integration of this proposed program into available crisis service (crisis team of 5 FTE who cover 24/7 365 days a year, psychiatry call 24/7 365 days a year, nursing services, CRT and outpatient services, and oversight by division leadership team) and other division resources will maximize service capacity.

In addition to submitting the attached financial tables, please provide any narrative information that you believe would help illustrate the financial impact and feasibility of this project. If the tables reflect anything significant that requires an explanation or clarity, please address this in the narrative.

Please refer to Proposed Budget and Budget Notes in Appendix A

6.2 Were any alternatives to this proposal considered and, if so, why were they rejected? Explain why you believe there are no other less costly or more effective alternatives to be considered.

No other alternatives to the proposed program have been considered. This RFP represents an opportunity to secure funding to implement this much-needed service, which has been a long-standing local system of care goal.

Appendix A

Budget and Budget Notes

VSH Futures Grant: NCSS Crisis Bed (2 beds) Program Budget				
REVENUE:	VSH Futures Project Grant		$	230,266
Possible Revenue:	Payment from other DA's for out-of-catchment CRT clients		$	15,000
Possible Revenue:	Respite funds if used by other divisions / DMH Crisis G.F.		$	8,350
Possible Revenue:	Walgrove Fund (funds donated to NCSS for CRT program)		$	2,500
	Total Revenue		**$**	**256,116**
EXPENSES:	**Staff**	**Hrs/week**	**Annual Cost**	
	Crisis Bed Staff #1 / Team Leader (1.0 FTE)	40	$	36,000
	Crisis Bed Staff #2 / Crisis Clinician (1.0 FTE)	40	$	32,000
	Supervision/Program Support (coordination of services, etc)	5	$	5,440
	Psychiatry ($75/hr)	4	$	15,600
	Nursing ($35/hr)	4	$	7,280
	Subtotal of Staff		**$**	**96,320**
	Fringe (32.5% of staff salaries)		$	31,304
	Total Staff Cost		**$**	**127,624**
	On-call staff:	**Hrs/week**		
Pager / On-call:	M-F, 8 am - 5 pm, $80 per week, 1 person	40 hrs	$	4,160
	Su - Th, 5 pm - 8 am, $125 per week, 2 people	75 hrs	$	13,000
	5 pm Fri - 5 pm Sun, $95 per weekend, 2 people	48 hrs	$	9,880
If called:	Awake evenings/overnight including phone support: $14/hr	30	$	21,840
	Asleep overnight: $7.50/hr	16	$	6,240
	Daytime hours (in person and phone support): $12/hr	30	$	18,720
	Total On-call expense		**$**	**73,840**
	Operating Expenses	**Per month**		
	Rent	$ 1,300	$	15,600
	Elec	$ 75	$	900
	Phone	$ 60	$	720
	Cable	$ 60	$	720
	Heat	$ 100	$	1,200
	Food	$ 100	$	1,200
	Cleaning / Trash Removal / Laundry	$ 70	$	840
	Supplies (Cleaning supplies, bedding & bath supplies, etc)	$ 250	$	3,000
	Staff Training	$ 100	$	1,200
	Peer Support Group Meetings & Trainings	$ 250	$	3,000
	Mileage/Transportation (600 miles/mo. @ $.42 per mile)	$ 252	$	3,024
	Total Operating Expenses		**$**	**31,404**
	Total Direct Expenses		**$**	**232,868**
	Administration Allocation (10 %)		$	23,248
	Total Expenses		**$**	**256,116**

VSH Futures Grant: NCSS Crisis Bed Program Budget Notes

General Notes:

- This is a proposal to develop a 2-bed crisis unit in Franklin County, with capacity to provide a continuum of crisis services based on individual situations.
- We will rent an apartment to be used primarily for this purpose.
- Use of the beds as a crisis bed will always be given first priority. If the crisis bed is not being used on a given night, the bed may be used for respite for CRT clients or clients from other divisions as appropriate.
- We will hire 2 full-time staff whose primary job will be to staff these beds when they are in use.
- When the beds are not in use, staff can be on-call, used as floats in CRT Residential, or as back up for our Agency Crisis Team. Depending on availability, these staff may also assist clients in the hospital Emergency Room.
- Therefore, these 2 staff will be of a higher training level, and one will be the team leader.
- Coverage is 24/7 for 365 days a year, and 2 staff will work 40 hrs/wk each.
- On-call staff will be needed to cover daytime hours when bed is in use and to cover regular hours when staff are sick or on vacation, or when extra help is needed.

Revenue:

The program as envisioned would cost just over 11% more than the proposed grant amount. We anticipate that other potential revenue sources can be used to help fund this program:

1. For CRT clients from other designated agencies who use the bed, there could be a "cash payment" made to NCSS out of their Caserate allocation to cover use of the bed.
2. If other divisions use an unused crisis bed as a respite bed for a night, that division would reimburse this program for use of the bed.
3. NCSS receives general funds from DMH to fund crisis services and some of this funding could be used to support this program.
4. NCSS received a donation from a couple formerly associated with this agency to establish a fund to pay for any unmet needs of our CRT population. We could set aside a small portion of this fund each year to support this program.

Expenses:

The expense portion of the budget is detailed within the budget itself. A few additional notes are as follows:

1. The Team Leader for this proposed program will be either a Master's level clinician with crisis experience or a Registered Nurse with crisis experience. This individual will be responsible for the daily operations of the program and, consistent with Team Leader job functions at NCSS, also provide direct services to consumers. The Team Leader will be the point person for contact and coordinate scheduling and operation of the program. The Team Leader will work closely with the Behavioral Health Division's Crisis, CRT, and Outpatient teams and will report to the Director of the Behavioral Health Division.
2. The Crisis Clinician for this proposed program will be either a Master's level clinician or bachelor's level with significant crisis experience. This individual will provide service in all component areas of the proposed program and will report to the Team Leader.
3. Given that the program will provide coverage 24/7, 365 days a year, a substantial on-call system will be needed to support the two full-time staff. The details of our proposed on-call system are outlined in the budget itself, and we feel that this is a realistic budget and one that we will be able to staff.
4. Start-up costs to fit-up the apartment (which are not in the budget) will come from an additional $2,000 of the Walgrove Fund and NCSS in-kind donations.

Appendix B

Implementation Plan

Implementation Plan

Northwestern Counseling & Support Services

Crisis Bed Program

(Draft) February 9, 2007

Pre-Implementation (Proposal Development)

X	Task	Due	Who	Status
	Announce RFP at Standing Committee Meeting	1/10/07	Division Director	
	Discuss design with consumers and community partners	1/10/07-2/8/07	ALL	
	Review at Agency Board Meeting	2/7/07	Executive Director	
	Review with Medical Center & monthly crisis coord. mtg	1/25/07	Div. Director & ER Director	
	Review with AHS Field Director	1/24/07		
	Letters of Support: a) Standing Committee b) Peer Support Group c) Medical Center d) Homeless Shelter	2/7/07		
	Review submission of proposal & modifications with Standing Committee	2/14/07	Standing Committee Mtg.	
	PROPOSAL TIMELINE			
	Letter of Intent to DMH	1/24/07	NCSS	
	Written Proposal Due	2/9/07	NCSS	
	Application ruled complete	2/19/07	DMH	

Pre-Implementation (following notification of Funding)

X	Task	Due	Who	Status
	Decision Notification	3/19/07	Health Comm.	
	Advertise & Hiring of Staff with Peer Involvement	3/19/07-4/20/07	Hiring Committee	
	Identify Apartment of Bed Options	3/20/07-3/30/07	Division Leadership	
	Develop staff and peer training schedule	3/20/07-3/30/07	Division Leadership & Peers	

X	Task	Due	Who	Status
	Meet with Standing Committee to identify program development & policy plan (form workgroup)	4/11/07 Meeting	Division Leadership and Standing Committee	
	First Workgroup Meeting to review & modify Implemenation Plan	4/14/07	Workgroup	
	Plan for Each Svs.Option: 1) CRT Outreach 2) Observ. Bed 3) Crisis Beds	4/14/07-5/31/07	Workgroup	
	Develop Operation Protocols	4/14/07-5/31/07	Workgroup	
	Develop Program Evaluations Timelines	4/14/07-5/31/07	Workgroup	
	Administrative review of Implementation plan & draft policies & procedures	4/14/07-5/31/07	Admin Intake, Division Leadership	
	Develop Meeting structure with Medical Center to plan Observation Bed option	4/24/07	Regularly scheduled Coord. Mtg.	
	Plan for community awareness campaign	4/14/07-5/31/07	Community Relations Office and Workgroup	
	Finalize Implementation Plan (Phase 1 & 2) with specific activities & timelines	4/20/07	Workgroup	

Appendix C

Letters of Support

Standing Committee
Division of Behavioral Health
Northwestern Counseling & Support Services

February 5, 2007
Dr. Steve Broer
Director, Behavioral Health Division
Northwestern Counseling & Support Services
107 Fisher Pond Road
St. Albans, VT 05478

RE: Letter of Support for Crisis Bed Proposal

Dear Dr. Broer,

As representative members of the Behavioral Health Division's Standing Committee, this letter is in strong support of the proposal to support a Crisis Bed service option for adults in Franklin & Grand Isle Counties.

Minutes from our Standing Committee meetings reflect a continuing need for local alternative services to prevent psychiatric hospitalization of adults who are in need of additional support to get them through a crisis situation. Our involvement in the development, review and support of the Behavioral Health Division's Local System of Care Plan continues to list the need to **"Increase community acute care and hospital diversion resources"**. Securing funding through the Request for Proposal process will be a very positive step in making this a reality for consumers in our area.

This letter also serves as a willingness to work with you and other providers in providing program development support and peer support services. As you know, we have representatives on our Standing Committee who facilitate our local peer support group. Our Standing Committee also has overlapping representation on several other boards to assist us in keeping informed about developments across the state (Vermont Psychiatric Survivors, State Standing Committee, National Alliance on Mental Illness). This proposed project is a great opportunity to develop on a partnership that we have all been working on through various activities in the division and larger community.

We look forward to further discussions on the design and implementation of this proposed program at our February's Standing Committee meeting.

Below are signatures of individuals representing our Standing Committee who were available to offer their indication of support.

Tom Moore
Malina Gonella
"Ronnee" Mauro
Cliff Anderson
Walter Lindor
Susan Towns
Pamela Anderson

Below are signatures of individuals representing our Standing Committee who were available to offer their indication of support.

Ray Halstead

Scott Dacke MacKenzie

Mary Sung Hee Hamm Feb. 6, 2007

Walter Gordon

Marcheta P Townsend

Peer Support Group & Services
Franklin & Grand Isle Counties

February 7, 2007
Dr. Steve Broer
Director, Behavioral Health Division
Northwestern Counseling & Support Services
107 Fisher Pond Road
St. Albans, VT 05478

Re: Crisis Bed Proposal/Letter of Support

Dear Dr. Broer,
I am writing to express my enthusiastic support for the proposed Crisis Bed Program!

The need for alternatives to hospitalization in Franklin & Grand Isle counties are well overdue. Far too many individuals who are in need of more intensive support when they are in a crisis are sent to hospitals away from their families and other supports. This type of "dislocation" can actually have a negative impact on someone's efforts towards recovery.

With the support of Vermont Psychiatric Survivors, we have been able to form a peer support group in our region. This group has been meeting for almost two years and has averaged a consistent attendance of 10 participants. Our peer support group has provided an invaluable forum for consumers to get support and advocate for necessary resources to promote recovery. Not a meeting goes by without a discussion about the need for crisis beds in our region.

I am particularly excited about the opportunity to develop peer support services to consumers who participate in the crisis bed program. There are a variety of models for peer support services and I believe our work with the Standing Committee and others has provided the necessary foundation for us to take peer support to the next level.

I wish you the best in securing funding for this desperately needed resource in our two county area.

Sincerely,

Jim Tomlinson
Peer Support Facilitator
Co-Chair, Behavioral Health Standing Committee
NCSS Board Member

Samaritan House

20 Kingman Street, Suite #1
St. Albans, Vermont 05478
"Serving Franklin and Grand Isle Counties"

E-mail: samaritanhouse@surfglobal.net
Web site: www.samaritanhouseinc.org
Telephone: (802) 527-0847

February 3, 2007

Dr. Steve Broer
Director, Behavioral Health Division
Northwestern Counseling & Support Services
107 Fisher Pond Road
St. Albans, VT 05478

Re: Crisis Bed Program Support

Dear Steve,

As the director of the only homeless shelter in the area, I am writing in strong support of Northwestern Counseling & Support Services efforts to develop a Crisis Bed Program in this region.

The Shelter employees have been frustrated on numerous occasions due to the fact that there was no crisis beds for folks to go to if their behavior was threatening or disturbing to other guests. Our program has experienced a consistent increase in adults with mental illness in need of crisis bed support. We have had to call the police when folks with mental health challenges were not able to comply with the rules of the shelter. This practice has been extremely troubling to me, as I do not like to put people out of the shelter, especially if I think they are vulnerable and do not have anywhere to go. Crisis beds would not only be a logical solution, but a humane one. There has to be a program that will assist folks who are not able to comply with rules, etc. I believe that a program such as the one you are proposing will help those who are vulnerable with an opportunity to have a safe place to stay while they are getting the treatment they deserve. Crisis beds will serve as a much needed resource for our program to refer to when someone is in acute psychiatric emergency and appropriate for a community based crisis bed.

The Shelter would also benefit from outreach services to CRT consumers. This would prevent a crisis from escalating and prevent homelessness of individuals who have limited resources.

We are in desperate need of this resource in our area. As you are well aware, this area has had limited resources for those who are most vulnerable. Best wishes in competing for funds to support the program.

Sincerely,

Linda A. Ryan

Linda A. Ryan
Executive Director

NMC
NORTHWESTERN MEDICAL CENTER

February 7, 2007

Dr. Steve Broer
Director, Behavioral Health Division
Northwestern Counseling and Support Services
107 Fisher Pond Road
St. Albans, VT 05478

Re: Support for Crisis Bed Proposal

Dear Steve,

After our conversation today, I felt it appropriate to forward at letter of my strong support for Northwestern Counseling and Support Services in your attempts to secure funding for a Crisis Bed Program for adults in Franklin and Grand Isle counties.

As Director of the Emergency Department here at Northwestern Medical Center, I have seen our Department, designed and built in 1990, seeing approximately 13,000 patients a year, grow dramatically to now being a Department with a volume of 29,000 patients annually. This steady increase in utilization has put our ED patient beds at a premium, and has required us to attempt to continually improve our systems to be as efficient as possible.

One of the difficult issues we are facing is the increased utilization of the Emergency Department with psychiatric emergencies. Not only is our volume of these patients increasing, but the duration of time that they spend in our Department in evaluation, and possible placement has become a significant issue in our patient flow. It is not uncommon to have a patient waiting for hours in our Department while a NCSS crisis worker tries to desperately get the patient accepted into one of our referral psychiatric units. We have tried to attempt facilitating patient flow by moving these patients into an "observation" status in the hospital, however, there are limitations in its effectiveness due to lack of staffing by behavioral health providers. Your proposal is very exciting in its attempts to aid in staffing of those observation patients. I would be very interested in working with you to consider the logistics of that support.

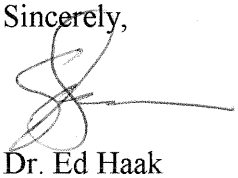
133 FAIRFIELD STREET
POST OFFICE BOX 1370
SAINT ALBANS, VT 05478

NMC: 802-524-5911
TOLL FREE IN VT:
800-696-0321

Further, the proposal could have significant impact on a number of other factors that effect our Department. By implementing an outreach option for adults with persistent mental illness, you could potentially prevent the patient from needing Emergency Department services by intervening with an in-home evaluation and crisis plan. With the potential availability of local crisis beds, this could again reduce the number of patients using the ED, as well as provide an alternative site for disposition from our Department in a much more timely, organized fashion.

The proposed Crisis Bed Program has the potential of offering our hospital, and especially our Emergency Department significant benefits. The Program would as well be a much more effective and personal manner of treating our psychiatric patients and their families. I applaud you in your efforts, and again forward my strong support for funding of this project.

Sincerely,



Dr. Ed Haak
Director, Department of Emergency Medicine
Northwestern Medical Center
St. Albans, VT 05478

Appendix D

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